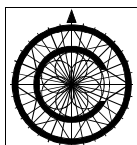


A Policy Analysis of Private Sector Participation in TB DOTS



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EXECUTIVE SUMMARY

Despite advances in medicine and government campaign to control tuberculosis in the Philippines, the disease remains a major policy concern. It is reported that the Philippines has the seventh highest TB incidence in the world and the second highest in Asia. Annually, disability and deaths due to TB result in an estimated P7.9 billion of foregone wages and benefits, and a total of P28 billion due to premature deaths from the disease (*A Study of the Socio-economic Burden of Tuberculosis in the Philippines, Philippine TIPS, February 2003*).

In 1996, the Philippine government adopted a proven cost-effective TB treatment strategy called the Directly Observed Treatment, Short Course (DOTS) under the National Tuberculosis Control Program (NTCP). Despite its vigilance, however, the government has met with only limited success in controlling TB in the country. This shortcoming has prompted a review of past policies and programs in relation to TB. A result of this review was a recognition of the need to involve the private sector in a public-private-mix TB control strategy. This strategy was affirmed in the Comprehensive Unified Policy for TB Control (CUP) which was ratified earlier this year by various stakeholders led by the Philippine Department of Health and the Philippine Coalition Against Tuberculosis (PhilCAT). Subsequently, the CUP received a much needed boost with the issuance of the presidential Executive Order No. 187 endorsing the Comprehensive Unified Policy for TB Control (CUP) and recognizing the public-private collaboration as key in fight against TB.

As a response to the identified need to secure greater support from the private sector in TB control and management it was determined that an evaluation of the implications of existing TB policies, programs and instruments on the decisions of private physicians to provide TB DOTS services is needed. This study aims to identify issues and recommend actions to help the private sector become a stronger partner of government in reducing the prevalence of TB through the implementation of DOTS.

According to this study:

- More than 50 percent of all Filipinos with TB either refuse or are unable to access modern medical treatment, with a sizeable proportion choosing self-treatment or to consult traditional healers.
- About a third of all Filipinos with TB symptoms who sought treatment prefer to consult private physicians for treatment. But a large number of private doctors seeing TB patients prefer, for various reasons, to use treatment options other than TB DOTS, a treatment preference which has serious implications on the quality of care that TB patients receive. Aside from addressing personal and professional issues behind the non-adoption by private doctors of the TB DOTS protocol, it's also necessary to see how government policies and programs related to TB help or hinder the adoption of TB DOTS by private doctors.
- Access to affordable and quality TB drugs is essential for full and effective treatment and is one of the cornerstones of TB DOTS protocol. And yet, outside of the public sector where TB drugs are available for free or at minimal cost, the prices of TB drugs have been found to be beyond the reach of poor patients.
- Financing for TB treatment is largely a private household burden. Despite the provision of TB treatment for free or at minimal cost in government facilities, families of TB patients still end up bearing a major part of the expenses entailed in TB management and control, much of which is

taken up by the cost of TB drugs. Without greater incentives and financial support at the individual household level, there is a great possibility that the patient will discontinue the course of treatment, a development which has grave implications not just for the health of the patient, but for the patient's immediate family as well.

How, then should the private sector, especially private medical practitioners, be encouraged to get more involved in TB treatment in line with the TB DOTS strategy? What government policies and programs are needed?

Current government policy encourages collaboration between government agencies and the private sector in the effort to manage and control TB. In fact, the recently issued presidential Executive Order No. 187 endorses the Comprehensive Unified Policy for TB Control (CUP) which recognizes public-private collaboration as key in fight against TB. It consolidates all government policies on TB with the aim of strengthening TB DOTS service delivery by the public sector. It also acknowledges the role of the private sector in the fight against TB. However, while the CUP sets out clinical guidelines on the full and proper treatment of TB patients following DOTS protocol by both government and private doctors, it contains no enforcement mechanisms to ensure compliance by private practitioners.

Of the various policies and programs reviewed, the most promising is the TB Outpatient Benefit Package of the Philippine Health Insurance Corporation (PhilHealth), which offers a financial incentive for the adoption of TB DOTS by the private sector.

This evaluation of government policies and programs related to TB indicates that policy interventions have been chiefly targeted at the public health care delivery system. At best, major interventions such as the National Tuberculosis Control Program (NTCP) and the TB programs of government agencies only provide information to the private sector. Most of the existing TB DOTS policies are not designed to elicit the participation of private physicians. At the same time, regulatory policies that affect private physicians are not particular to TB DOTS.

Of utmost urgency are policy changes addressing two major concerns:

- Ensuring patients' quality of care from private physicians, and
- Assuring completion of treatment through continued access to affordable and quality TB drugs.

This study recommends that the role of the private sector be enhanced through accurate diagnosis and appropriate treatment. Appropriate knowledge and training through continuing education and financial incentives can stimulate participation of the private sector to follow TB DOTS. Addressing the problem of continued access to quality TB drugs will involve formulating policies with which stakeholders across both public and private spheres will agree. Among the identified key players are the Department of Health and its Bureau of Food and Drugs which regulate the entry and availability of drugs in this country; the drug industry, including suppliers, manufacturers and retailers; and the end-users, public and private doctors and their patients. Pooled procurement of drugs that result in economies of scale can ensure access to affordable and quality TB drugs.

While the government wishes to strengthen public-private partnerships in TB management and control, as shown by the adoption of the CUP that recognizes the role of the private sector in the campaign, it needs to define partnering arrangements with the private sector in a more deliberate and assertive manner. Policies providing financial incentives to private doctors who follow TB DOTS protocol, such as the PhilHealth benefit package, are certainly promising. Beyond financial incentives, the government must also map strategies to ensure greater compliance among private

doctors with TB DOTS, through information and education campaigns, the enforcement of standards, especially among laboratory personnel to inspire doctors' confidence in their findings, and assuring patients a continuous supply of TB drugs by helping to bring down prices outside of the public sector.

ACRONYMS

AHMOPHI	Association of Health Maintenance Organizations of the Philippines
BFAD	Bureau of Food and Drugs
CHD	Center for Health Development
CUP	Comprehensive and Unified Policy for Tuberculosis Control in the Philippines
DepEd	Department of Education
DILG	Department of the Interior and Local Government
DOH	Department of Health
DOTS	Directly Observed Treatment, Short Course
ECC	Employees Compensation Commission.
EO	Executive Order
FGD	Focus Group Discussion
GDF	Global Drug Facility
GSIS	Government Service Insurance System,
HMO	Health Maintenance Organization
HSRA	Health Sector Reform Agenda
HSRA	Health Sector Reform Agenda
IEC	Information Education Campaign
IRR	Implementing Rules and Regulations
MDR	Multi-Drug Resistant
NEDA	National Economic and Development Authority
NTCP	National Tuberculosis Control Program
NTPS	National Tuberculosis Prevalence Survey
PDI	Parallel Drug Importation
PHIC	Philippine Health Insurance Corporation
PhilCAT	Philippine Coalition Against Tuberculosis
PHS	Philippine Health Statistics
PMA	Philippine Medical Association
PPM	Public-Private Mix
PSP	Private Sector Participation
SSS	Social Security System
TB	Tuberculosis
UNHP	Urban Health and Nutrition Program
WHO	World Health Organization

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I. INTRODUCTION

The Philippine Department of Health (DOH) reports that in 1996 TB ranked fifth among the ten leading causes of death and illness (mortality and morbidity) in the Philippines. In 1999, the World Health Organization (WHO) ranked the Philippines second to Cambodia in the Western Pacific Region in terms of new TB cases. The 1997 National Tuberculosis Prevalence Survey (NTPS) found only a marginal decline in the annual risk of TB infection from 2.5 percent to 2.3 percent in the 15 years since the previous NTPS survey in 1982-83. Other estimates are no less alarming. In 2000, the WHO projected that there were 249,655 new cases of TB in the country. This placed the Philippines in seventh position among the countries with the highest TB incidence in the world, and the second highest in Asia.

Apart from the toll in human lives and health, TB exacts a heavy toll on the economy, too. The disease afflicts a significant proportion of the male population of income generating age. Partial economic losses due to foregone wages are estimated at P7.9 billion, or roughly two percent of the country's Gross Domestic Product in 2002. And as long as TB incidence remains at currently high levels and has the capacity to infect more than half of the country's population, these losses are likely to increase, dampening the country's development prospects.

TB kills and can leave infected individuals too weak to work or care for their loved ones, becoming a burden to their families who are in danger of getting infected themselves. And yet TB is curable and, once an infected person starts getting treatment, his or her capacity to infect others is minimized if not eradicated, and the person should be able to return to full productivity in no time.

Clearly, TB as a public health problem need not remain as intractable as it seems to have been for the greater part of the last century. While the first organized TB control measures were initiated by the private sector, particularly the Philippine Tuberculosis Society, Inc. which was founded in the early 1900s, TB these days has become primarily a government concern, addressed mainly by government health institutions and providers. And yet, a significant proportion of Filipinos with TB seem to prefer to consult private doctors. If the Philippines is to make any headway in the management and control of TB, it seems evident that the private sector needs to be encouraged to play a bigger role in the campaign. At the same time, government must ensure that patients receive only the highest quality of care, meeting standards of treatment that have already been proven effective and accepted worldwide.

In 1996, the government adopted the Directly Observed Treatment, Short Course (DOTS), a proven cost-effective treatment protocol for TB, under the National Tuberculosis Control Program (NTCP). Since then, public hospitals and health facilities have increasingly used the DOTS protocol, with its five essential components:

DOTS Elements

- Political commitment to provide the necessary funds and enact the necessary policies and laws to control TB
- Case detection by sputum smear microscopy among symptomatic patients self-reporting to health services
- Standardized treatment regimen of six-eight months for at least all confirmed sputum smear positive cases, with directly observed treatment for at least the initial two months
- Regular, uninterrupted supply of all essential anti-TB drugs

- Standardized recording and reporting system that allows assessment of treatment results for each patient and of the TB control program overall.

The adoption of the DOTS protocol by government has led to impressive gains in TB control and management efforts. Despite proof of the efficiency and effectiveness of DOTS, however, the private medical sector, particularly the physicians, have yet to fully embrace DOTS as the treatment protocol of choice for their TB patients. Many reasons have been advanced for the private sector's resistance to adopting DOTS, among them doctors' continued reliance on x-rays as their primary diagnostic tool, and excessive regulatory and monitoring policies that make it difficult or inconvenient for private doctors to adopt DOTS.

One area of inquiry deemed necessary for the creation of wider public-private partnership in TB control is a review and evaluation of existing TB policies, programs and instruments and how these influence the decisions of private physicians and the rest of the private health sector to provide TB DOTS services.

Study Objectives

This study seeks to answer the following questions:

- What policies and programs encourage or discourage private sector participation in TB control efforts?
- What new policies or revisions are needed to make the adoption of DOTS more attractive to private physicians?
- How can the government encourage the adoption of DOTS by private doctors while ensuring that they meet standards of quality care?
- What other policy options and issues can be explored to strengthen the partnership of government and the private sector in the fight against TB?

Government policies, programs and instruments for TB control can be analyzed in terms of their direct and indirect effects on the decisions of the various players involved, whose choices and actions ultimately affect health outcomes. Embedded in government policies are sets of incentives and constraints that either positively or adversely affect the choices not only of the targeted players, but often also those of other players in the market for TB DOTS services. There are four sets of players in the market for TB DOTS services, namely: service users (or consumers), health financing institutions (or third-party payors), the service providers (or suppliers), and the government (comprising national government agencies and local government units). Since the choices of all the market players jointly determine the health outcome, a full accounting of the intended and unintended consequences of policies is therefore necessary.

Many policies are promulgated with only indirect reference to TB, but which have implications on the supply of and demand for TB services. Restrictive licensing requirements for hospitals and laboratory facilities, for example, could limit the availability of sputum microscopy in private health facilities. Thus, with the mapping of policies onto the elements of DOTS strategy, it may be possible to spot the inconsistencies, conflicts or overlaps in the different government policies and programs. Appropriate corrective measures may then be adopted.

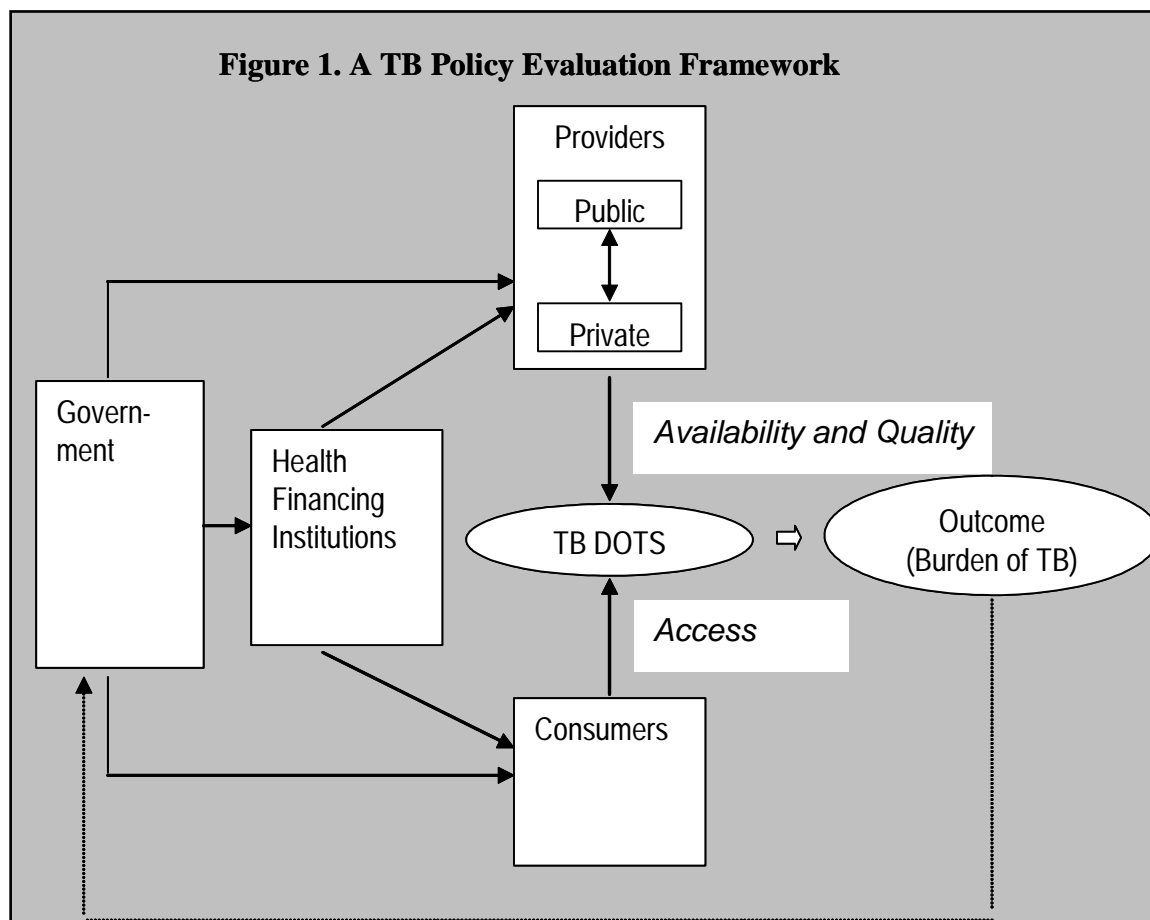
Evaluation Methodology

The methodology used in this study involved both quantitative and qualitative analyses of available survey data, review of relevant literature and public documents, interviews of key informants, and the conduct of focus group discussions.

To guide the policy inventory and analysis, a market-oriented evaluation framework was designed for this study. The framework identifies the key players in the market for TB services, the relationships between and among these players, and the linkages between policies, the interactions of the players and health outcomes. The framework was used to organize the findings from the review of relevant literature and documents, from the analysis of secondary data, and the feedback from the interviews of key informants and from the participants in the focus group discussions.

To obtain a reasonable perspective of the range and the relative impact of different TB policies on the decision of private physicians to participate in the TB DOTS program, secondary survey data (2001 UNHP, 2002 PhilCAT Survey of Physicians, 2001 PhilHealth claims database) and summary tables of survey data (1997 NTPS) were compiled. Despite the extensive breadth of these data sets, they were still of limited use since these surveys were not conducted specifically for evaluating the impact of TB policies on the private sector. To augment the collected secondary survey data, efforts were expended to collect first-hand data, though only of limited reach. Towards this end, the study team canvassed physician consultation fees, lab fees and drug prices. The limited canvass of fees and prices was employed to estimate the average cost of TB DOTS treatment for a Category 1 patient.

The evaluation framework designed for this study traces the possible effects of TB policies. In Figure 1, the major players in TB DOTS services are identified (in boxes), their interrelationships are traced (by arrows), and the linkages between policies, players' decisions and health outcomes are depicted (by broken lines). The evaluation framework is essentially a market-based one since the market is the relevant setting for most physicians engaged in private practice. Though important, the physicians in the voluntary or non-profit sector constitute only a minority and their actions or decisions are also likely to be conditioned by market forces. Moreover, the market often provides useful benchmarks to assess the efficiency and equity of government interventions.



The framework used classified the existing TB policies and programs into those that essentially affect the provision (i.e. supply-side interventions) or the utilization (i.e., demand-side interventions) of TB DOTS services. Some policies did not easily fit into either of these two categories; therefore, their classification was arbitrary. Nonetheless, the simple scheme leads to two evaluation criteria, namely: the impact of supply-side interventions on the availability and quality of TB DOTS services provided in the private sector, and the impact of demand-side interventions on the consumers' access to TB DOTS in the private sector.

From another perspective, policies were also evaluated in terms of their relevance to the different elements of TB DOTS strategy: political commitment, access to quality assured TB sputum microscopy, directly observed treatment using standardized short-course chemotherapy, uninterrupted supply of quality-assured drugs, and recording and reporting system.

II. THE POLICY ENVIRONMENT

Since TB was identified as a major public health problem in the Philippines, its eradication and control have been a top priority of government. In 1932, Republic Act No. 3473 created the TB Commission under the then Philippine Health Service to provide impetus to TB control efforts. This was followed by other efforts to control TB, the latest being Executive Order No. 187 issued on March 21, 2003, recognized the Comprehensive Unified Policy for TB Control as the new public-private strategy against TB. Despite its vigilance, however, the government has not been totally successful at its efforts, prompting others to review past policies and programs with the objective of strengthening and introducing innovations into the current TB programs.

A. Supply-side Policies

Through supply-side policy interventions, the government outlines the direct provision of TB services in the public health sector and issue regulatory policies that affect all health professionals and facilities. The government also implements financing schemes and programs to improve the access of health service users to providers. An inventory of current government policy instruments done for this reveals its strong commitment to directly influence the availability and quality of TB treatment services provided while its financing programs indicate its desire to facilitate access by patients.

Among the policies and programs that directly concern the availability and quality of TB DOTS services in the public sector, the most significant are:

- The Health Sector Reform Agenda (HSRA) and the National Tuberculosis Control Program (NTCP) of the Department of Health
- TB Prevention and Control Program of the Department of Education
- Local Government Tuberculosis Control Strategy of the Department of the Interior and Local Government, and
- Support to the National TB Control Program of the National Economic and Development Authority.

However, these interventions do not provide the mechanisms to facilitate private sector participation. They merely provide information to the private sector, and thus, do not fully encourage private sector involvement in TB DOTS. At worst, these programs may even have adversely affected private sector participation. A look at the design and implementation features of these policies is instructive:

1. **The National TB Control Program is directed primarily at the public health system.** Information and education campaigns concerning TB DOTS and other incentive schemes are directed at government doctors and facilities. Publicly procured TB drugs are distributed at government health centers. Also, it does not include, much less specify a function for, the private sector in the list of health workers tasked to carry out the NTCP.
2. **The TB programs adopted by other national government agencies apply only to their own employees and dependents, such as those of the Department of Education and Department of National Defense.** Further, the TB DOTS service providers in these agencies are also government workers.

3. **DILG Memorandum Circular No. 98-155 only vaguely defines public-private partnerships in local TB control.** It does not specify how such partnerships may be formed, mobilized and sustained. Also, it appears that the implementation of this policy is not monitored.
4. **Applicable NEDA policy directly concerns only private voluntary activities in TB control, thus excluding the majority of private physicians.**
5. **Current occupational health and safety standards do not prescribe the application of TB DOTS.** Thus, the private corporations are allowed to choose their own mode of TB treatment.

Arguably, the regulatory requirements are imposed to ensure that quality care standards are followed for the protection of the patient. The full impact of these policies, however, largely depends on their enforcement. But it appears that the enforcement capacity of implementing agencies is very limited.

In their study on access by the poor to affordable drugs, Lim and Pascual [2002] report that the Bureau of Food and Drugs (BFAD), an agency under the DOH, lacks the appropriate capacity to ascertain the quality of medicine through inspection, registration and licensing of drug manufacturers. Further, the authors conclude that "...only 16 of the 80 or so pharmaceutical manufacturers are 100% compliant with current good manufacturing processes. There are complaints that culprits responsible for counterfeit and substandard drugs are not properly prosecuted and punished." The personnel resources of the NTCP are also reportedly inadequate, largely as a result of the streamlining of the DOH bureaucracy in the late 1990s. This results in delays in the retrieval of quarterly NTP reports and the reduced number of field visits and supervision by the DOH and CHD TB staff.

Recent policy developments, though, ascribe an expanded role for the private sector in the national campaign against TB. Specifically, Executive Order No. 187 mandates the collaboration between the national government agencies on the one hand, and private sector organizations, on the other, in the conduct of an information and education campaign for the Comprehensive and Unified Policy for Tuberculosis Control in the Philippines (CUP). Those in the private health sector enjoined in the campaign are the Philippines Coalition against Tuberculosis (PhilCAT), Philippine Medical Association, and the Association of Health Maintenance Organizations of the Philippines. Furthermore, the CUPTCP deputizes the PhilCAT to carry out monitoring and accreditation functions.

Other recent DOH initiatives include the Health Sector Reform Agenda (HSRA) and its implementing guidelines (DOH A.O. #37, s. 2001) and the promotion of DOTS services in private clinics. The HSRA sets among the national health objectives the increased DOTS coverage to 100 percent of the population and the increased compliance among private doctors with the National Consensus on TB Diagnosis and Treatment. In line with the promotion of DOTS, the DOH in 2002 has formally agreed with United Laboratories, Inc. (Unilab), a private corporation, to supply Unilab with TB drugs to be used for the treatment of TB patients in its clinics.

B. Demand-side Policies

Unlike supply-side policies, demand-side policies and programs only indirectly affect private sector participation in TB DOTS. While these policies are designed to stimulate the demand for TB services, however, they could influence the patient's decision to seek treatment and, even less so, his or her choice of health service provider. The principal demand-side policies and programs are:

- The social health insurance packages of the Philippine Health Insurance Corporation (PhilHealth), and

- The disability payment policies of the Government Service Insurance System, Social Security System and Employees Compensation Commission.

While not specifically intended for TB, the total benefits provided by PhilHealth, SSS, GSIS and ECC to their members who used such benefits for TB treatment are substantial. For example, PhilHealth, SSS and GSIS together paid close to P100 million in 2001 for TB treatment. While no estimates exist, a portion of this amount was spent presumably for privately-provided TB services. There is need, though to align compensation policies, especially of the SSS, GSIS and ECC with TB DOTS guidelines.

In April 2003, PhilHealth adopted a new benefit package that promotes TB DOTS in the private sector. Now called the TB Out-patient Benefit Package, the new program extends the flat rate of a P4,000-benefit to each qualified member or a dependent for outpatient TB treatment in accredited DOTS clinics or providers, which may be public or private. However, the amount shall be released directly to the DOTS center in two payments: P2,500 upon the initiation of treatment, and P1,500 upon successful completion of the treatment. Originally planned for implementation in seven DOTS clinics, the new program is currently being fine-tuned with the help of Philippine Coalition against Tuberculosis (PhilCAT), a multi-sector coalition of groups working against the disease. The detailed design and implementation features of the program will prove critical in engaging the private sector in TB DOTS.

To conclude, most of the existing TB DOTS policies are not designed to elicit private physicians' participation; and regulatory policies that affect private physicians are not particular to TB DOTS. However, the CUPTC and the PhilHealth's TB OP benefit package are initial steps in the right direction.

III. FINDINGS AND POLICY RECOMMENDATIONS

A. Political commitment

Viewed from a policy lens that involve the five elements of DOTS, the various TB and TB-relevant policies arrayed according to their relevance to the specific DOTS elements reveal specific areas for policy intervention.

In the public sector, all elements of the DOTS strategy are directly promoted by a number of supply-side policies ([See Annex 1: Inventory of Policies Relevant to the Elements of DOTS Strategy, page 29](#)) namely: Health Sector Reform Agenda and DOH O#37, s. 2001; National TB Control Program, National Economic Development Authority Support to NTCP; Department of Education's –TB Prevention and Control Program; and the Department of Interior and Local Government's Memorandum Circular #98-155.

In contrast to the other government agencies, however, only the Department of Health (DOH) and the Department of Education (DepEd) are in a command position to carry out fully the DOTS strategy, owing to their mandates and own TB programs. While these policies allow for private sector participation in TB DOTS, they need to be amended to include specific roles and functions for private physicians, and the possible terms of reference for public-private partnerships in TB DOTS. The partnership may involve patient referrals, access to drugs and lab facilities, and maintenance of a TB patient registry.

Two recent policies explicitly cite the involvement of the private sector in all aspects of TB DOTS. One, EO 187, s. 2003 provides at least the enabling environment for public-private partnership in TB DOTS as specified in the CUPTC. In contrast, the new TB-OP Benefit Package of PhilHealth offers more than an enabling environment. It is a financial incentive meant to entice private physicians to adopt the DOTS protocol. To the accredited physician, the new insurance program may yet lead to a windfall, provided that a number of design and implementation issues are addressed at once. Among these issues are the caps on professional fees, public-private referral system, access to cheap drugs for private TB patients and the expansion in the number of certified DOTS centers.

Providing financial incentives are justified by findings in this study that show that in addition to the social stigma and poor information that discourage a person with TB from seeking treatment, the decision to see a doctor or visit a clinic also depends on the household's financial resources. The TB Health Account Matrix prepared for this study ([See Table 11. Estimates of the Sources and Uses of Funds for TB Control in 2001 \(in thousand pesos\), page 19](#)) shows that households constitute the biggest sources of funds for battling TB. The common view is that since TB is a communicable disease it therefore must be primarily a government burden. But the accounting of TB funds in 2001 shows that 56 percent (or P309.5 million) of the total constitutes the households' share, significantly exceeding the 33 percent-share of the government. This suggests that households bear a bigger financial burden than the government, despite the fact that TB is a public health concern and that the government has identified the control of the disease as among its top health priorities.

Moreover, while it is widely believed that TB services are provided free of charge in public hospitals and clinics, households still seem to be spending a fairly large amount to avail of these services. Estimates show that in 2001 households spent P124.8 million for these services, or 40.3 percent of their total TB expenditures. While this may be due to the fact that TB DOTS services are more readily available in public than in private health facilities and that TB drugs are provided free in government facilities, a significant percentage (37 percent) of the total household payments was spent on private providers. In 2001, this amounted to P115 million.

B. Quality of Care Provided by Private MDs

1. Why is it necessary to seek out and encourage greater private sector participation in TB control and management efforts?

The results of the 1997 NTPS show some disturbing patterns of health seeking behavior among Filipinos with TB. (Table 1). More than one-third (34.5 percent) chose not to seek any form of treatment, while more than a fourth (27.5 percent) resorted to self-care or sought treatment from traditional healers. The rest of the population of those with TB went to see a health professional, initially either in a public health center (15.5 percent), private clinic (10.4 percent), public hospital (9.8 percent) or private hospital (2.3 percent). The failure of individuals with TB to seek any medical attention is disturbing because, aside from the potential health risks they face, they may unwittingly be exposing others to the same health risks as well.

Table 1: Treatment-seeking by the TB Afflicted (in percent)

Provider/Facility	Initial Provider	Subsequent Provider
No treatment	34.5	
Self care/traditional healer	27.5	
Public health center	15.5	6.4
Private clinic	10.4	0.8
Public hospital*	9.8	1.6
Private hospital*	2.3	0.4

Source of raw data: 1997 NTPS. *Hospital proportions were generated using the 2001 UHNP End-of-Project Evaluation Survey.

2. Why do so many individuals with TB refuse to seek treatment despite the availability of publicly provided TB services throughout the country?

One oft-cited reason is the social stigma attached to TB being a “poor man’s disease.” A study conducted by Dr. Grace Ortaleza (*Vignettes on TB Stigmatization, 2003*) shows that most informants remain ignorant or poorly informed about the causes, spread or transmission, recognition, or proper treatment of TB. The stigma attached to TB forces patients to isolate themselves from the rest of the community, with the other members of their families affected by the same stigma, too. The general public’s low level of knowledge about TB is disturbing, despite the fact that more and more people are exposed to TB campaigns on TV, radio and print media (*SWS Surveys on Tuberculosis*). Clearly, a more effective and extensive information and education campaign is called for.

The 1997 NTPS also reveals that a significant proportion of TB patients seek professional medical care from private providers (Table 2). The study shows that around one-third of those with TB go to either private clinics or private hospitals. This clearly indicates that private health care providers play a vital role in the control and management of TB in this country.

Table 2: Choice of Initial TB Treatment Providers (in percent)

Provider/Facility	Initial Provider
Public health center	40.8
Private clinic	27.4
Public hospital*	25.8
Private hospital*	6.0

Source of raw data: 1997 NTPS. *Hospital proportions were generated using the 2001 UHNP End-of-Project Evaluation Survey.

3. *Why do Filipinos with TB resist or postpone seeking treatment for the disease, despite the availability of services and drugs in public health centers? And when they do seek treatment, why does such a large number prefer to see a private physician?*

Based on the review of previous studies and the feedback from key informants and participants during the focus group discussions held for this study, the following observations could help explain the household preference for private providers:

- Irregular supply of TB drugs in public health centers;
- Limited attention extended by public physicians to their patients (who are more comfortable consulting a doctor rather than a midwife or a nurse);
- Superior interpersonal skills of the staff in private facilities;
- Relative anonymity accorded to patients in private facilities (which help them avoid TB stigma in public facilities); and
- Parents tend to bring their children for treatment in private health facilities, even though they themselves may not seek any treatment or go first to public providers (thus the high proportion of pediatric TB cases in the total patient load of private providers).

Obviously, the informants' preference for private doctors and services can be attributed to other quality aspects of private medical care, not necessarily DOTS. Indeed, further analysis of the 2002 PhilCAT Survey reveal that, although a significant number of private physicians reported awareness of DOTS, very few of them have the requisite competence to deliver DOTS or comply with the prescribed protocols for case finding and case holding. Table 3 shows that a majority (75 percent) of the doctors engaged in purely private practice are aware of DOTS; although when probed further, a variable and smaller percentage of the sub-sample of medical doctors interviewed knew each of the elements of DOTS (Table 4).

Table 3: Awareness of DOT among Medical Doctors

Practice Setting	Total Number	Percent Aware
Mixed Practice	25	76.0
Pure Private	160	72.5
Total	185	73.0

Source of data: 2002 PhilCAT Survey of 188 MDs.

Table 4: Awareness of DOT elements among Medical Doctors

DOT elements	Total Number	Percent Aware
Diagnosis through sputum smear microscopy	63	52.4
Availability of TB drugs	63	58.7
Recording and reporting system	63	42.3
Requires a treatment partner	63	63.5
Political commitment	63	25.4

Source of data: 2002 PhilCAT Survey of 188 MDs.

1. Low use of sputum smear microscopy in case detection

Perhaps of greater policy concern is the fact that only a small proportion of doctors comply with the NTCP-prescribed initial TB diagnostic procedure and treatment regimen for various categories of TB patients. Table 5 shows that 41.4 percent of doctors did not use AFB Smear Test as the initial TB diagnostic procedure and only 5.4 percent of these doctors use AFP Smear Test alone, contrary to the NTCP guidelines. At least two out of five private physicians do not use smear exam initially.

2. Non standardized treatment regimen

Further, Table 6 shows that only 22 percent of the doctors in purely private practice appear to have followed the NTCP-prescribed chemotherapy short course for new smear-positive cases (Category 1), but none of them observed the suggested drug regimen for those who reported treatment failure (Category 2). Only in the case of smear-negative cases (Category 3) did the majority (about 65 percent) of doctors with purely private practice appeared to have complied with the suggested drug regimen. These findings are broadly supported by other studies (*e.g.*, *Portero and Rubio [2002]*; see box inset).

Table 5: Choice of Initial TB Diagnostic Procedures

Practice Setting	Number of MDs	Did not use AFB Smear Test (%)	Used AFB Smear Test (%)		
			Only	With X-ray	With X-ray and PPD
Mixed Practice	25	28.0	24.0	28.0	20.0
Pure Private	161	43.5	2.5	28.0	26.1
Total	186	41.4	5.4	28.0	25.3

Source of raw data: 2002 PhilCAT Survey of 188 MDs.

Table 6: Percentage of MDs who followed the NTCP-Prescribed TB Drug Regimen

Practice Setting	Followed NTP-Prescribed Drug Regimen by Type of Patient		
	Category I/(new smear+)	Category II/(treatment failure)	Category III/(new smear -)
Mixed Practice	27.7/(11)	0/(8)	72.7/(11)
Pure Private	21.6/(51)	0/(42)	64.7/(51)
Total	22.7/(62)	0/(50)	66.1/(62)

Source of raw data: 2002 PhilCAT Survey of 188 MDs. Note that the figures in parenthesis are the total number of MDs who reported to have prescribed TB drugs.

Feedback from key informants and the participants during the FGDs, point to several factors that could explain the limited capacity of the private sector to deliver TB DOTS services, including:

- Lack of NTCP awareness, especially of the suggested drug regimens for various categories of patients;
- Perceived incompetence or inadequacy of public health staff to undertake spectrum microscopy;
- Lack of DOTS training in medical school;
- Complaints raised by patients regarding the difficulty of expectorating sputum, and the poor guidance provided by public health staff;

- Incentives (like honoraria, sponsorship to conferences) provided by the pharmaceutical companies to follow their own suggested drug regimen; and
- Lack of coordination between public and private providers in the treatment of patients referred to public health facilities (which results in the duplication of exams).

These and other factors will be discussed in greater detail in succeeding chapters, with policies mapped according to their relevance to specific DOTS elements. An issue that has serious implications on the capacity of private doctors to provide quality care following the TB DOTS protocol is their lack of knowledge of and familiarity with the elements of TB DOTS. This is borne out by the findings of a recent poll conducted among physicians treating TB patients:

Private physicians' lack of knowledge and familiarity with the elements of TB DOTS

Based on a telephone interview of 1355 private physicians (constituting 57.9 percent out of the total 2340 private physicians identified):

- The private physicians diagnosed TB mainly through X-ray findings (87.9 percent).
- The private physicians did not follow-up their TB patients, they did not trace the defaulters (97.9 percent) and did not study the contacts (91.4 percent).
- Only 24.2 percent of the private physicians knew in depth the National Tuberculosis Program (NTP).
- They defined the weakest points of the NTP being the diagnosis through sputum microscopy (59.2 percent) and the management of smear negative patients (27.9 percent).
- The majority of the private physicians wish to collaborate with the NTP (83.3 percent), although economic compensation (38.4 percent) is also deemed important.
- More than half was against obligatory case report of the TB cases.
- The private physicians based their success in attracting TB patients to their offices on the confidentiality (46.1 percent) and on the kind of treatment and the flexibility (43.7 percent).

From: Portero and Rubio [2002]. "Private practitioners and tuberculosis control in the Philippines: Strangers when they meet?" Medicos del Undo Spain Tuberculosis Project in the Philippines.

3. Unsure access to regular, uninterrupted supply of TB drugs

Critical to the success of TB DOTS treatment is the patient's continuous access to reliable TB drugs and microscopy centers. Often, however, patients in private clinics who otherwise have limited financial resources are referred to public health centers where such drugs and laboratory exams are provided free of charge or at minimal cost. Thus, the physician's knowledge regarding such public health facilities is important to the completion of TB treatment. The 2002 PhilCAT survey shows that more than about 93 percent and 61 percent respectively of private doctors know a health facility where either TB drugs are distributed for free or sputum smear exams are done at no cost to the patient. It should be noted, however, that referrals to these facilities, which are likely to be government health centers, do not ensure patients access to these services. Feedback from private practitioners suggests that some patients are not able to

avail readily of such services without undergoing the requisite diagnostic procedures in the public health facilities.

Table 7: Physicians' Awareness of Health Facilities that Provide Free Services and Drugs for TB Patients

	Percent of Medical Doctors who are aware of	
	A health facility that offers TB drugs for free	A microscopy center that offers free sputum smear exams
Mixed Practice	25 (100%)	17 (68.0%)
Pure Private	115 (92.7%)	75 (60.5%)
Total	140 (94.0%)	92 (61.9%)

Source of raw data: 2002 PhilCAT Survey of 188 MDs.

4. Non-standardized recording, reporting and monitoring

Another critical element of DOTS is record-keeping and monitoring of TB patients, especially as they begin their short course chemotherapy. It appears that more than 90 percent of private physicians included in the 2002 PhilCAT survey appear to maintain clinical records of their TB patients' compliance with drug intake (Table 8). When probed further, however, a majority of the private physicians limited their monitoring to simply asking their patients whether they took their drugs. Thus, record-keeping and monitoring in the private sector may not necessarily follow the requirements of the DOTS protocol.

Table 8: Physician Practices on Recording and Monitoring of TB Patients

Practice setting	Percent of Medical Doctors who	
	Maintain clinical records of their TB patients	Monitor their TB patients' compliance to drug intake
Mixed Practice	10 (90.9%)	23 (92.0%)
Pure Private	104 (95.4%)	148 (94.3%)
Total	114 (95.0%)	171 (94.0%)

Source of raw data: 2002 PhilCAT Survey of 188 MDs.

Quality assurance concerns on TB treatment in private sector

In summary, there are three policy issues concerning the provision of TB DOTS by private physicians, namely:

- Their continued reluctance to use AFB Smear Test as the principal diagnostic procedure (apparently because of a lack of confidence in the qualifications of laboratory personnel to correctly assess the findings of sputum smear tests);

- Their lack of knowledge of or compliance with the prescribed drug regimen for various types of TB patients which requires extensive record-keeping and monitoring; and
- The need to ensure their patients' access to drugs and laboratory facilities.

Policy Options

To address these issues, the private physicians themselves may adopt self-regulatory policies within their own medical societies. Peer pressure or acclaim, moral suasion, membership in medical societies are some of the regulatory instruments available to the private sector that can be used to promote TB DOTS among their ranks or used by the public sector to prod private doctors into greater compliance. PhilCAT is an example of a private sector initiative, and in recent times the organization has been working closely with the Department of Health and the World Health Organization in promoting TB DOTS in the private sector. While PhilCAT is a broad coalition of health professionals, perhaps a similar initiative may be encouraged within the individual medical societies, especially those involved in the treatment of TB like the Philippine Academy of Family Physicians.

It seems clear that existing regulatory policies are not able to ensure that patients receive quality care from private practitioners, including accurate sputum microscopy services, uninterrupted supply of TB drugs, or the appropriate recording and monitoring of the treatment regimen. Given the apparent neglect of the role of the private physicians in the TB control program, it is not surprising that TB DOTS in the private sector is inadequate: meager supply, inferior quality and yet more expensive.

To address issues of quality of care (save for access to a continued supply of TB drugs which will be discussed in the next section), the following options for policy interventions and research are suggested:

Knowledge of and familiarity with TB DOTS

- Advocate for the inclusion of TB DOTS in basic medical education.
- Introduce DOTS modules in the continuing medical education of physicians.

Adoption of sputum smear tests as primary diagnostic tool

- Require all medical technologists and laboratory personnel that administer sputum tests to undergo the appropriate training and certification for the purpose. Publish or advertise the list of certified health professionals.

Overall quality of care

- Improve the regulatory capacity of the Bureau of Food and Drugs, the Bureau of Licensing and Regulation, and other concerned government agencies to ensure reliable drug quality and competence of technologists.

C. *TB Drugs Policy*

The parallel drug importation (PDI) policy¹ does not help the TB patient have access to cheap TB drugs. While the PDI policy is designed to bring down the domestic price of essential drugs, it does not include any of the TB drugs for importation through the PDI facility. While a separate TB drug procurement system with the same intended results as PDI may be currently employed, the PDI system seems more adaptable to elicit the participation of private drug suppliers and local government units. Reportedly, some local government units procure their own TB drugs from private drug suppliers to supplement their quota of TB drugs from the DOH. To bring down the price of drugs further, private drug suppliers may also have to be allowed to participate in the PDI system.

Bringing down the prices of TB drugs is of vital importance since the required chemotherapy constitutes the biggest cost component of TB treatment. In addition, the government's budget for TB control remains limited (the WHO-estimated funding gap for 2003 is US\$5.8 million). Reportedly, both the landed cost and the average retail price of imported TB drugs in the country are higher than is warranted. For example, a six-month TB DOTS regimen for Category 1 patient would cost around P5,390 (blister packs) or P8,450 (loose drugs), when the drugs are purchased from drugstores in Metro Manila. When the drugs are bought through the Global Drug Facility, however, the total cost of drugs for the same drug regimen is only about P910 (fixed dose). While this claim is not investigated here, for it will require a detailed cross-country cost or price comparison, it is broadly supported by previous studies.

In their review of domestic drug prices, Solon and Bauzon [1999] reports a wide range of retail prices for several drugs, including that of a box of 100 capsules of Rifampicin 450 mg., as shown in the table below. It is obvious from the table that the price variation between generic and branded products is considerable; it is also noteworthy that prices within each drug category also vary. The authors examined the possible reasons for the price differences, including: expensive marketing strategies adopted by manufacturers and distributors of branded drugs, the monopolistic structure of the private drug distribution network, the supposed greater bio-efficacy of branded drugs and differences in the patterns of demand, non-tariff barriers and the limited capacity of government to provide information on quality and prices to the general public.

Table 9: Domestic Retail Price of Rifampicin 450 mg/capsule 100's box

	Manufacturer	Price
Low Generic	Axon	440.00
Medium Generic	Pacific	480.00
High Generic	Alman	510.00
Low Branded	Koshmed by Vitalink	577.00
Medium Branded	Rexilan by Am-Europharma	1,233.54
High Branded	Fampisec by San Marino	1,999.70

Source of table: Solon and Banzon [1999].

Indeed, from a recent report (Philippine Business Profiles and Perspectives: 2002-2003), only a few drug distributors and retailers dominate the domestic drug industry. In 2001, the combined market share of Zuellig Pharma Corporation and United Laboratories Incorporated in the wholesale trade was 41 percent. In the same year, Mercury Drug controlled 87 percent of the retail trade gross revenues. Thus, the

¹ As enunciated in AO#56, s. 1989; AO#85, s. 2000; AO#69, s. 2001; DO #367-H, s. 2001; AO #70, s. 2002; and AO #70-A, s. 2002.

promotion of competition in the drug distribution industry and the strengthening of the regulatory capacity of BFAD would be necessary to bring down the prices of drugs to a more affordable level.

Prospects: Global Drug Facility

Recently, the Philippines was given a US\$1.5 million grant under the Global Drug Facility (GDF). Initiated by WHO in 2000, the GDF is “a global mechanism to ensure the uninterrupted access to quality TB drugs for DOTS implementation.” The grant constitutes globally procured, quality assured TB drugs to be released in three batches: the first batch of TB drugs for 5,000 cases is to be released in 2003; the second batch for 20,000 cases will come in 2004; and the third batch for 50,000 cases will come in 2005. Under the terms of the GDF grant, the drugs shall be provided for free to all TB DOTS patients and in support of the National TB Control Program.

It is likely that the domestic drug industry will resist the suggested use of the GDF procurement system by private practitioners or DOTS centers, in much the same way that they have complained about the adverse effects to them of the parallel drug importation policy. Although it is difficult to satisfy all drug suppliers and manufacturers with a single policy, it is nonetheless consistent with the objective of ensuring adequate TB drug supply to allow suppliers to participate in the PDI or use the GDF system, whenever possible. This should be open to all to ensure that no monopoly over cheap imported TB drugs will arise that will defeat the purpose of the new procurement system.

Other options on the matter of ensuring continuous TB drug supply are the following:

- Develop a facility for pooled procurement of TB drugs by private DOTS providers. They could be given access to the regular procurement program of the DOH or the Global Drug Facility.
- Issue clear guidelines regarding the appropriate drug regimen for various types of TB patients. Mandatory compliance with the fixed dose combination may be necessary to control the types of drug combination available in the market. This issue also concerns pharmaceutical companies, which have the capacity to influence the prescription practices of doctors. Close coordination with drug companies in the implementation of guidelines on the use of the SCC drug regimen may thus be necessary. The role of drug companies, however, should not be limited to coordination. Most of the fixed dose TB guidelines should also prescribe the appropriate fixed dose combination, with mandatory compliance enforced.

D. PhilHealth and the Financing Gap

Unlike previous TB policies, the PhilHealth TB benefit package represents an explicit financial incentive to adopt DOTS that may yet appeal to many private practitioners. Specifically, an accredited private DOTS provider or DOTS center is relatively assured of a captured market, i.e. PhilHealth members and beneficiaries with TB. In addition to the guaranteed caseload, the accredited provider is allowed some flexibility in allocating the P4,000-benefit amount among the various treatment components. Consequently, the provider can get a higher amount out of the P4,000 than the normal professional fee. Moreover, a provider is better assured of payment since it is made by PhilHealth rather than by the patient, who is likely to be indigent. More importantly, perhaps, PhilHealth accreditation, which is largely a market signal for quality DOTS services, may also serve as a badge of distinction among one's peers.

The success of the new TB-OP insurance program critically depends on a number of factors, to be discussed below.

A critical factor would be the adequacy of the P4,000-support value for each TB patient who seeks treatment in private DOTS centers. This does not seem to be the case, as can be seen from Table 11 where a schedule of out-of-pocket payments by a Category 1 TB patient is presented. The estimates are based on a selective canvass of professional fees, laboratory fees and retail drug prices in Metro Manila. Although the prices in the seven initially-identified DOTS centers² are ideal, the estimates presented below are better indicators of the range of prevailing fees and charges in the private sector.

Expectedly, a Category 1 TB patient will shell out for a full-course treatment between a low-end estimate of P6,990 and a high-end estimate of P14,398. If a patient can and does avail of the new PHIC TB OP benefit package, then his or her direct out-of-pocket payments will be reduced to between P2,990 and P10,398. At least 50 percent of the cost of medication will be for drugs. Thus, the affordability of treatment in the private sector depends a lot on the availability of cheap TB drugs.

Table 10: Physicians' Awareness of Health Facilities that Provide Free Services and Drugs for TB Patients

	Percent of Medical Doctors who are aware of	
	A health facility that offers TB drugs for free	A microscopy center that offers free sputum smear exams
Mixed Practice	25 (100%)	17 (68.0%)
Pure Private	115 (92.7%)	75 (60.5%)
Total	140 (94.0%)	92 (61.9%)

Source of raw data: 2002 PhilCAT Survey of 188 MDs.

A TB drug procurement facility for all private DOTS centers can be set up to pool their procurement orders and bargain for a lower price. Private DOTS centers should also be allowed to participate in the GDF procurement system.

The new PHIC TB OP benefit package is a welcome opportunity to enhance the participation of the private physician in TB DOTS. Potentially, the total financial package could reach up to P1 billion, calculated on the basis of the estimated 250,000 new TB cases annually (*A Study of the Socio-economic Burden of Tuberculosis in the Philippines, PhilTIPS 2003*) and assuming, of course, that each of these cases is eligible to receive the TB OP benefit package.³ Arguably, this amount can be leveraged to elicit greater provision of TB DOTS services in the private sector, bring down the price of TB drugs, or facilitate other financial mechanisms that will help ensure the viability of private DOTS centers.⁴

To strengthen the features of the PhilHealth TB OP benefit package, guidelines and procedures must be set so that even smear-negative TB patients who are otherwise eligible can still avail of the TB OP benefit package. These should ensure that both smear-negative and smear-positive TB patients would have equal access to TB DOTS services.

² The seven DOTS centers are Unilab, UST, Makati Medical Center, La Salle-Cavite, FriendlyCare Cubao, Pasig District Hospital, Manila Doctors Hospital.

³ Note that the PHIC is mandated to achieve universal coverage.

⁴ These insights were contributed by Prof. Emmanuel Leyco, Philippine TIPS Policy and Health Financing Advisor, to the study team.

Table 11: Estimates of the Sources and Uses of Funds for TB Control in 2001 (in thousand pesos)

[back to Political commitment](#)

Uses	Sources				Government			PhilHealth (Currently In-Patient only)	ECC	Pvt. Ins/ HMO	NGO	Com- pany	Total
	Household Payments	SSS Benefit Payments	GSIS Benefit Payments	Total	NTP	FAP	LGUs						
Public Health Center				35,027		Not avail.	Not avail.						
Public Hospital	271,619	28,508	9,337	124,831	183,000			59,798	Not available				Not available
Private Clinic				115,016									
Private Hospital				34,590									
Self-Care/ Traditional Healer	Not available			Not available									Not available
Total	271,619	28,508	9,337	309,463	183,000	Not avail.	Not avail.	59,798	Not available				552,262 (underesti- mate)

Note: Shaded cells indicate that these accounts do not exist. "Not available" means that these accounts cannot be estimated with the available data and the resources available to the study team.

Notes: Out-of-pocket TB expenditures are calculated using the NSO population projection (medium) for 2001, the 1997 National TB Prevalence Survey (NTPS) prevalence rate and medical provider utilization ratios, and the 2001 End of Project Urban Health and Nutrition Survey (UHNP) average out-of-pocket TB treatment payments to providers. The number of TB patients seeking treatment from different providers is calculated by multiplying the estimated total number of TB patients with the utilization rates from the 1997 NTPS. The total number of TB patients is calculated as the product of 77,898, 184 (2001 NSO (medium) population projection) times 3.1/1000 (1997 NTPS prevalence rate) divided by 2.2 (1997 WHO duration of disease estimate) divided by .45 (1997 WHO smear positive rate). Household payments by providers are calculated as number of TB treatment users by provider times the average out-of-pocket TB treatment payments.

Government TB expenditures are based on estimated NTP expenditures for 2003. These estimates do not enable breakdown by type of facility. Apparently, some LGUs also spend for supplemental drug supplies. However, the total amounts, together with those coursed through Foreign Assisted Projects (FAP), can only be estimated in a more comprehensive data collection effort.

PhilHealth TB expenditures are derived from in-patient claim payment estimates provided by PhilHealth to PhilTIPS. The provided estimates do not enable breakdowns by type of facility.

SSS disability payments and medical expenses for TB cases are for 2002 and presently cannot be broken down by facility.

GSIS disability payments and medical expenses for TB cases are for 2001 and presently cannot be broken down by facility.

ECC disability payments and medical reimbursements for TB cases are not available because the information system is still under construction.

The amount of funds generated by NGO's, Company provided benefits and HMO's can only be estimated in a more comprehensive data collection effort.

IV. OTHER RECOMMENDED POLICY SUPPORT INITIATIVES

To flesh out some of the policy options outlined previously, the following additional research inputs are recommended:

- A comprehensive mapping and assessment of private sector capacity, treatment and pricing practices, and willingness to participate in TB DOTS. The relevant doctor's characteristics would include the location, practice setting, patient profile, fee schedule, expertise and training, and knowledge and awareness of TB DOTS.
- A comprehensive and updated National TB Prevalence Survey to include socio-economic variables and health financing information.
- A market study of TB services in a number of areas or settings. The market study will be a documentation of the nature of competition, cooperation or segmentation between public and private sectors. The study will likewise identify the relevant factors that could explain the observed interaction between public and private providers, and in the process suggest policy interventions that could promote collaborative arrangements between the two types of service providers.
- A mapping of PHIC membership in terms of health status (whether TB symptomatic), location, employment and education, income and demographic features, and HMO coverage. Such information will be useful in the calibration of the PHIC TB OP benefit package to maximize benefits to members and their dependents.
- A fully-developed TB accounts health matrix that can be used to identify financing burden and gaps to help formulate targeted financing policies.
- Technical assistance in crafting the Implementing Rules and Regulations (IRR) of the PhilHealth TB OP benefit package, especially in the specification of economic and financial standards that will ensure the viability and replicability of DOTS centers.
- Aside from providing technical assistance towards the rapid expansion of PhilHealth's TB DOTS program, an assessment must be conducted on the recovery of costs involved in the certification and monitoring of DOTS centers. The unit costs of monitoring the initial DOTS centers may not be reflective of the prospective costs incurred if a rapid expansion of PhilHealth's TB DOTS program is achieved, so a cost recovery mechanism has to be in place before the rapid expansion takes place.
- Technical assistance to the design of the models of public-private mix (PPM). At present, there are several private-public partnership models of TB DOTS provision. Not much, however is known about the networking between public and private physicians as well as among private physicians in the provision of TB treatment. The possibility of having different PPM appropriate in different areas gives added impetus to understanding the networking between physicians.

The first step in shedding light on the issue involves a mapping of physicians. Although this involves extensive fieldwork, this has to be done since it is also critical in drafting the implementing rules and regulations for the PhilHealth TB OP Package.

The second step involves an assessment of the referral system between physicians. This information may not be retrieved in the mapping of physicians and separate case studies may have to be undertaken in selected areas nationwide. These case studies will have to probe deeper into the

different collaboration schemes feasible across physicians belonging to different practice settings and specializations. For example, would general practitioners be more comfortable with the role of gatekeepers referring patients to DOTS centers after diagnosis or would they prefer a more active role as consulting physician during treatment?

In addition to the evaluation of the networks between physicians, an evaluation must also be made on the nature of collaboration between the government (DOH) and TB DOTS centers/private physicians. Should the role of government be limited to advocacy and IEC? Can the government provide support infrastructure such as a TB drug procurement system that would reduce the cost of procuring TB drugs? At present the DOH plans to procure drugs for all TB patients. Although it is understandable that not all TB patients in the private sector can avail of these drugs, an examination of alternative drug distribution mechanisms may identify an effective TB drug distribution system that would ensure that TB DOTS centers receive an adequate and timely supply of TB drugs.

V. CONCLUSION

The private sector can best help in TB control through accurate diagnosis and appropriate treatment of patients who seek their services. But most of the existing TB policies, at best, have only weakly encouraged the participation of private physicians in TB DOTS. Policies that explicitly promote TB DOTS are largely designed for and implemented in the public sector. On the other hand, other TB-related programs and regulatory policies that explicitly concern the private sector are not particular to DOTS. Moreover, existing regulatory policies do not ensure compliance with key elements of TB DOTS: quality TB sputum microscopy services, the uninterrupted supply of TB drugs, or appropriate recording and monitoring of TB patients in the private sector. Given the apparent neglect of the role of private physicians in the TB control program, it is not surprising that only a few private doctors follow the TB DOTS protocol in their treatment of TB patients, with no means of monitoring the quality or consistency of their course of treatment.

Still, the situation is not beyond saving.

The adoption of TB DOTS in the private sector is likely to increase and improve with the recent introduction of the PhilHealth Out-patient Benefit Package. Together with this new insurance package, the full implementation of the Comprehensive and Unified Policy for TB Control in the Philippines may yet institutionalize a wide and effective public-private partnership. Although these two initiatives are laudable, they alone are not the answer to the country's TB problem, which would also require amendments in the other TB policies.

One promising area of policy reform is accessibility to quality drugs, particularly drug pricing, since the required chemotherapy constitutes the biggest cost component of TB treatment. It has been found that the cost of treatment is a major factor influencing a person with TB's decision to seek or not to seek treatment for the disease. Concern over their patients' continued access to TB drugs is also a reason cited by doctors to explain their reluctance to adopt TB DOTS protocol. A review of drug pricing policies, as well as regulations on the manufacture, importation and distribution of drugs, is therefore necessary.

Although changes in the policy environment could draw in greater numbers of private physicians and institutions in the struggle to control TB, work also needs to be done on reshaping the social environment. TB is not just a deadly but curable disease. It is also a social disease, which if left undiagnosed or untreated hampers the individual's ability to earn a living, be productive, mingle freely among one's friends, workmates and neighbors. It thrives on ignorance, prejudice and shame. But it can be eradicated with the concerted efforts of medical personnel in the public and private sectors, as well as the openness

and willingness of our national and community leaders to bring TB once more to the forefront of public attention and advocacy.

VI. TECHNICAL NOTES

Evaluation Criteria

The overall study design and the TB policy evaluation framework were first presented to the public during the Policy Roundtable Discussion held on March 19, 2003 (See Annex 4 for the list of participants during this consultation). The lists of key informants and participants in the series of FGDs held for this study are contained in Annex 5.

Once the policy inventory was accomplished, the different policies were evaluated in order to identify gaps, inconsistencies, or weaknesses that must be addressed to enhance the role of the private physicians in TB DOTS. The policy evaluation was carried out at two levels.

At the first level, the different policies were assessed in terms of relevance to TB DOTS as a whole or to specific elements of the DOTS strategy. The clustering facilitated the cross-referencing of particular provisions that were not consistent with the objectives of the NTCP. Thus, once classified, the policies that needed to be amended to achieve the desired objective were then prioritized.

At the second level, the impact of policies on the behavior of the suppliers and consumers of TB DOTS were inferred from available data and from the results of the FGDs and key informant interviews. In particular, the supply-side interventions, on the one hand, were assessed in terms of their impact on the availability and quality of TB DOTS services in the private sector. On the other hand, the effects on access to TB DOTS services in the private sector became the basis of the review of demand-side interventions.

DOTS Providers

The supply side of the market consists of service providers that include public and private health professionals, facilities, and the sellers of drugs, medicines and equipment. They vary in location, practice setting, cost and pricing protocols, residency training, years of practice and, most importantly, willingness to provide TB DOTS services. However, these characteristics are often within the control of the service provider, and, therefore, may be influenced by financial and non-financial factors.

Two sets of information are critical to the formulation of policies that will enhance the participation of private physicians in TB DOTS, namely: their existing capacity (knowledge, availability) to deliver TB DOTS services; and the factors that influence their willingness to provide adequate and quality-assured TB DOTS services. Thus a profile of all doctors in the country is essential. The profile would include information on their competence and capacity to deliver DOTS, treatment and pricing practices, and patient load characteristics. With this information, appropriate policy instruments like information dissemination, social recognition, or financial incentives may then be adopted to enhance the participation of private doctors in providing TB DOTS.

Unlike most markets, the market for TB treatment involves a third party that directly pays the service providers and insures the service users against losses due to TB. The third-party payers include both the public and private health financing institutions. Clearly, therefore, the particulars of the benefit coverage and reimbursement schemes adopted by these institutions will determine not only the health seeking behavior of the insured TB patients but also the effective participation of private doctors in the market for TB services. Thus the following sets of information are critical:

- The membership profile of the different health financing institutions;

- The amount and nature of benefits extended to eligible members and dependents;
- Accreditation policies and reimbursement schemes concerning service providers.

These data would enable policymakers to assess the extent of insurance coverage of people with TB, the effective benefits received by the insured population and some of the factors that limit private sector participation in TB DOTS.

Role of Government

The government is the single biggest and most influential market player. Relative to each of the other players, it has more resources, controls more potent instruments to influence others, and has the bigger mandate to eradicate TB in the country. This mandate to eradicate TB has its economic basis.

The first economic rationale concerns the inefficiency of the market due to demand-side externalities. Such externalities arise when a TB patient may not be aware of the full consequences of incomplete treatment, which include the increased risks of infection imposed on others and the likelihood of the patient's developing a Multi-Drug Resistant TB strain. Even if patients are fully aware, however, they may still not complete treatment because they have not yet fully internalized the social benefits of TB cure, while individually patients bear the full cost of treatment. Consequently, patients would seek a lower level of treatment than socially warranted if left on their own. Government intervention is thus justified.

Equity consideration is another rationale for government intervention. Since TB afflicts the poor more than any other income groups, the poor shoulder a disproportionate share of the economic burden of TB and suffer a lower quality of life. Thus government intervention is warranted to improve the health of the poor, and thereby expand their economic opportunities and enhance their quality of life.

Since both reasons arise from weakness or failures on the demand side of the market, demand-side policy interventions like social health insurance therefore are the most appropriate, other things being equal. However, given resource constraints and the difficulty of targeting and monitoring TB-afflicted population groups, supply-side interventions such the public provision of services are employed.

Health Financing Institutions

Social health insurance and public provision of services are the better known TB interventions. In addition, the government also influences the choices of market players in other ways. The other forms of interventions include the conduct of advocacy, information and education campaigns and the regulation of market players. Accreditation, licensing, certification, and other regulatory policies essentially restrict the actions and number of service providers for quality assurance purposes.

In general, however, the different forms of government interventions may be directed at the demand-side, supply-side, and financing-side of the market. For example, subsidies and other tax breaks may be granted to HMOs (financing side) or private hospitals and clinics (supply side). Regulations and licensing requirements are imposed on HMOs and all hospitals in the country. Likewise, the practice of medicine and other health professions is regulated through board exams. Yet, some policy pronouncements are simply meant to coordinate the actions and expectations of the various market players.

Often, however, policy interventions in one side of the market lead to unintended and possibly adverse reactions from the other sides of the market. To illustrate, while public provision of TB services may bring down TB incidence, it may also crowd out private providers who may not be able to compete with

subsidized prices in public hospitals and other health facilities. Thus, a full evaluation of both the intended and unintended consequences of TB policies, especially as these impinge on the decisions of private physicians, is necessary.

TB DOTS services

TB DOTS services have special features that differentiate it from other available products in the market. First, TB DOTS is essentially a bundle of goods and services, whose clinical and economic values are diminished if consumed incompletely. An incompletely treated patient poses greater clinical risks because of the likelihood of developing a multi-drug resistant TB strain which is more difficult and more expensive to treat. Moreover, an incompletely treated patient may also unwittingly expose others to TB, thus increasing the economic burden of the disease. Since a complete course of treatment is necessary, this would require commitment of both financing and time from the patient. Various incentive schemes like health insurance and company-provided health services are some mechanisms that help secure the patient's commitment to staying the course.

The other critical feature of TB DOTS as a product is that it is an *experienced good*, i.e., its true quality can only be ascertained once consumed. It is unlike a *search good* whose quality is easily ascertained through ocular inspection. Given the potential and irreparable harm of substandard TB DOTS services to the patient's health, then quality should be foremost among the factors influencing a patient's decision to avail of TB DOTS services from a service provider. This is the reason the quality of TB DOTS services is an important policy issue, and therefore, the main rationale for regulations.

The demand side of the market comprises the segment of the population that needs TB DOTS services. Besides the overall health status of the population, however, the other primary policy concern is the public's effective access to TB DOTS services. The factors that influence health-seeking behavior of consumers of TB services include financial, psychological, physical or socio-economic factors. Among the most relevant to policy of these factors are the consumer's knowledge and awareness of TB, household income, direct and indirect costs of TB treatment, insurance coverage and the social stigma attached to TB.

VII. BRIEF DESCRIPTION OF DATA SOURCES

- *1997 National TB Prevalence Survey (NTPS)* – Nationally representative survey of individuals and households. Cluster sampling of 21,96
- 0 respondents. Contains data on prevalence rates, treatment seeking decisions, and limited set of demographic variables (age, gender). Limitation: no socio-economic variables. Used to calculate BOD, diagnosis and treatments seeking by facility.
- *1997 Philippine Health Statistics (PHS)* – Contains morbidity and mortality data. Limitation: Summary tables only
- *2001 Urban Health and Nutrition Program (UHNP) End of Project Evaluation Survey* – Survey of Households in UHNP and Non-UHNP covered areas, stratified sampling, 2205 respondents, limited to Metro Manila, Cebu City, and Cagayan de Oro City. Contains socio-economic variables, TB incidence, treatment seeking and limited cost data. Limitation: enriched sample, data accessible. Courtesy of Dr. Orville Solon. Used to estimate TB prevalence rates, TB treatment seeking by facility, and to calculate out-of-pocket TB treatment cost by facility.
- *2002 Philippine Coalition against Tuberculosis (PHILCAT) Survey of Physicians* – Survey of 188 medical doctors of various practice settings in Metro Manila and Cavite. Contains demographic characteristics of MDs, patient load, diagnostic, treatment and patient-monitoring practices, and awareness of health facilities for PTB and DOTS. Limitation: not representative and some ambiguous questions. Used in calculating the capacity of private doctors in case finding and in case holding of TB cases according to DOTS requirements.
- *2003 Policy Analysis of Private Sector Participation in TB DOTS Study Team Canvass of Professional Fees, Laboratory Fees and TB Drug Prices* – Canvass of physician consultation fees, smear and x-ray fees, and selected TB drug prices in Metro Manila.
- *2003 Policy Analysis of Private Sector Participation in TB DOTS Study Team Key Informant Interviews and modified Focus Group Discussions* – Interviews of experts in the field of TB services and health care financing. Group discussions with family physicians, specialists and financiers of TB treatment.

The information from survey data was further supplemented through interviews with key informants and modified focus group discussions. Valued for their expert opinions, the selected key informants are authorities in the medical profession and in the health-financing sector. Among the topics covered by the interviews were overall awareness and practice of TB DOTS by private providers, perceptions regarding the NTCP and other regulatory policies of the government, as well as incentives needed to stimulate the participation of private physicians in TB DOTS.

The pool of key physician informants was chosen after consultations with Dr. Rodrigo Romulo and Dr. Charles Yu, two well-respected specialists in infectious diseases and pulmonology. The pool of health care finance experts were chosen after consultations with highly respected researchers.

The findings from the secondary data and key informant interviews were validated through three focus group discussions. Focusing on health financing issues, the first FGD was conducted with representatives of PhilHealth, SSS and Fortune Medicare. The second FGD was conducted with family physicians, who are at the forefront of health service delivery and, therefore, often can influence a patient's choice of TB treatment regimen. The last FGD was conducted with chest physicians and specialists in the treatment of

infectious diseases, experts who should be able to provide advice on how best to maintain DOTS standards in the private sector.

Given the resource and time limitations of the study, the findings reported in this policy analysis may not be free from bias. Therefore, the policy options suggested are best taken together as the general direction for subsequent government interventions to enhance the effective role of private physicians in TB control

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Annex 1: Inventory of Policies Relevant to the Elements of DOTS Strategy

Policies	Elements of DOTS Strategy*					Remarks
	Political Commitment (Financing)	Directly Observed Treatment	Access to TB Sputum Microscopy	Adequate Supply of TB Drugs	Recording and Monitoring	
Supply-Side Interventions						
Health Sector Reform Agenda						
DOH A.O. # 37, series 2001						
National TB Control Program						
NEDA-Support to NTCP						
DepEd- TB Prev. and Control Prog.						
DILG Memo. Circular # 98-155						
E.O. # 187, series 2003 (CUPTC)						- Amend to delineate a specific role for private MDs and the terms of partnership between public and private providers of TB DOTS.
DOLE-OSHS		Allows all employers to choose TB treatment regimen for employees				- Issue another E.O. to fully operationalize the CUPTC.
Food, Drugs and Cosmetics Law				Drug regulatory policies apply to both public and private sectors		- Require annual physical exams of employees to be consistent with NTP
Pharmacy Law						- Monitor compliance in the private sector
						- Undertake information and education campaign
						- Adopt incentives to countervail the ones offered by private drug companies
Hospital Law			Affects availability of lab facilities			- Should be consistent with certification requirements for TB DOTS
Government Procurement Reform Law			Applies to all procurement in the public sector.			- IRR should help insure availability of TB drugs in RHUs and DOTS centers.
E.O. # 49, series 1993				Applies only to the public sector		- Promote PNDF in the private sector
Supply-Side Interventions						
Generics Drug Law				Promote generic drugs for TB and other diseases in the public		- Monitor compliance in the private sector
DOH A.O. # 51, series 1988						- Undertake information and education campaign
DOH A.O. # 55, series 1988						
DOH A.O. # 62, series 1989						
DOH A.O. # 63, series 1989						- Adopt incentives to countervail the

Policies	Elements of DOTS Strategy*					Remarks
	Political Commitment (Financing)	Directly Observed Treatment	Access to TB Sputum Microscopy	Adequate Supply of TB Drugs	Recording and Monitoring	
Supply-Side Interventions						
DOH A.O. # 65, series 1992				and private sectors		ones offered by private drug companies
BFAD Circular # 01, series 1997						
DOH A.O. # 56, series 1989						
DOH A.O. # 85, series 2000				Parallel importation to lower prices of selected drugs, excluding TB drugs		- Include TB drugs in the list
DOH A.O. # 69, series 2001						- Allow local government units, private hospitals/drug distributors to participate in the importation of TB drugs
DOH D.O. # 367-H, series 2001						
DOH A.O. # 70, series 2002						
DOH A.O. # 70-A, series 2002						
Demand-Side Interventions						
PhilHealth TB OP Benefit Package	Directly promotes all DOTS elements in both the public and private sector					No caps on professional fees; ensure patient's access to free drugs; certify more DOTS centers
(Regular) PhilHealth TB IP Benefit Package			The beneficiary may choose his provider, who then suggest the TB treatment regimen			Amend to require sputum smear exam as part of annual physical exam, keep records and monitor treatment of workers with TB
GSIS-Disability Benefit Program						
SSS-Disability Benefit Program						
ECC-Employees' Compensation Program						

* *Gray areas mean no direct relevance.*

Annex 2: Inventory of Policies to Promote TB Services

Policy (Implementing Agency)	Main Provisions/Features	Implications for private MDs' participation
Health Sector Reform Agenda (HSRA) (DOH)	<ul style="list-style-type: none"> - A comprehensive strategy to reform the public health sector, including key public health programs like TB control - Sets investment targets for TB control; sets target percentage of private doctors complying with the National Consensus on TB diagnosis and treatment - <i>Guidelines on the Operationalization of the Health Sector Reform Agenda Implementation Plan by all Bureaus, Programs, Offices, Centers for Health Development and Attached Agencies of the Department of Health</i> - Delineates the roles of the different divisions and attached agencies of the DOH in the implementation of the five strategic reform initiatives in the health sector 	<ul style="list-style-type: none"> - For information
DOH Administrative Order No. 37, series 2001 (DOH)	<ul style="list-style-type: none"> - The NTPC is the government's main anti-TB policy. The NTPC officially adopted the DOTS strategy in 1996 (with the issuance of A.O. No. 24). The NTPC Manual of Procedures specifies guidelines and instructions for case finding and case holding for all government health workers involved in TB Control. 	<ul style="list-style-type: none"> - For information
National Tuberculosis Control Program (NTCP) (DOH)	<ul style="list-style-type: none"> - <i>Instituting a Comprehensive and Unified Policy for the Tuberculosis Control in the Philippines</i> - Mandates the collaboration among key national government agencies, health financing institutions, and private sector organizations: <ul style="list-style-type: none"> - To adopt DOTS as the basis of implementation of TB control in the country, and within each national government agency; and - To conduct the dissemination of, and the training on, the Comprehensive and Unified Policy for TB Control in the Philippines (CUPTCP) 	<ul style="list-style-type: none"> - For information - Enjoins the participation of PhilCAT, PMA and AHMOPHI in the IEC and training related to CUPTC
Executive Order No. 187, series of 2003 (Comprehensive and Unified Policy for Tuberculosis Control, CUPTC) (DOH, all NGAs, private sector orgs.)	<ul style="list-style-type: none"> - Program components consist of case finding, treatment, information education and communication, capability building, and monitoring and evaluation - Adopt DOTS protocol: use chest X-ray examinations and sputum microscopy in screening TB cases among all primary and secondary school teachers and non-teaching personnel; provide drugs to category I and category II TB patients; follow up and monitor treatment of TB positive cases. 	<ul style="list-style-type: none"> - For information - Occasional joint anti-TB activity with Cure TB foundation, PTSI and Glaxo Smithkline
TB Prevention and Control Program (TPCP) (DepEd- School Health and Nutrition Center)	<ul style="list-style-type: none"> - As specified in DILG Memorandum Circular No. 98-155 - Enjoins all LGUs to pass a resolution declaring TB Control as the No. 1 public health program for 1998-2004, to adopt DOTS, and to create an Anti-TB Task Force comprising public health personnel, representatives from local medical schools, civic organizations and private medical practitioners 	<ul style="list-style-type: none"> - For information - Enjoins the participation of the private medical practitioners in local anti-TB programs

Policy (Implementing Agency)	Main Provisions/Features	Implications for private MDs' participation
(DILG)	<ul style="list-style-type: none"> - Enjoins all LGUs to make every public health center or facility a DOTS unit, with the requisite trained manpower, microscopy services, anti-TB drugs, and reporting books to monitor progress of patients. - Identifies best local practices in TB Control 	
Support to the National TB Control Program (SNTCP) (NEDA)	<ul style="list-style-type: none"> - NEDA coordinates the formulation, evaluation and monitoring of socioeconomic policies and programs consistent with the national development objectives. Principally, the NEDA - Facilitates the inclusion of programs and projects in support of the NTP in the Medium-Term Public Investment Plan - Monitors the progress of implementation of ODA-Assisted TB control programs - Assists in the evaluation for tax deductions of private donations for TB control programs and projects 	<ul style="list-style-type: none"> - For information - Regulate private voluntary contributions to TB control programs and projects
Occupational Safety and Health Standards (OSHS) (DOLE)	<ul style="list-style-type: none"> - Promulgated under the <i>Labor Code of the Philippines</i> - Specifies the standards and procedures for the adoption of occupational safety and health services in all workplaces in the Philippines. Also, it mandates the company health programs for workers to include the provision of trained occupational safety and health personnel, the provision of first-aid kits and emergency medicines and facilities, periodic conduct of health examinations, immunization programs, and health education and counseling 	<ul style="list-style-type: none"> - For information - Possibly increase the demand for industrial physicians and for TB diagnostic/treatment services
Republic Act No. 6675 (Generics Drug Act of 1988) (DOH)	<ul style="list-style-type: none"> - <i>An Act to Promote, Require, and Ensure the Production of an Adequate Supply, Distribution, Use and Acceptance of Drugs and Medicines Identified by their Generic Names</i> - Mandates the use of generic names in all transactions related to purchasing, prescribing, dispensing, and administering of drugs and medicines in the public and private sectors. - Also specifies the applicable penalties for violations 	<ul style="list-style-type: none"> - For information - Regulate drug prescription/dispensing
Republic Act No. 3720 (Food, Drugs and Cosmetic Act of 1963), (DOH)	<ul style="list-style-type: none"> - <i>An Act to Ensure the Safety and Purity of Foods, Drugs, and Cosmetics being made available to the Public by creating the Food and Drug Administration which shall administer and enforce the laws pertaining thereto</i> - Mandates the standardization and quality of food, drug and cosmetics, and the adoption of measures to insure pure and safe supply of food, drug and cosmetics in the country. - Establishes within the DOH the Food and Drug Administration, now the Bureau of Food and Drugs (BFAD) 	<ul style="list-style-type: none"> - For information - Regulate drug mfg
Republic Act No. 5921 (Pharmacy Law of 1969), (DOH)	<ul style="list-style-type: none"> - <i>An Act Regulating the Practice of Pharmacy and Settings Standards of Pharmaceutical Education in the Philippines and Other Purposes</i> - Mandates the standardization and regulation of pharmaceutical education, and the supervision, control and regulation of the practice of pharmacy in the Philippines 	<ul style="list-style-type: none"> - For information - Regulate drug mfg
R.A. No. 4226 (Hospital Act of 1965), (DOH)	<ul style="list-style-type: none"> - <i>An Act Requiring the Licensure of All Hospitals in the Philippines and Authorizing the Bureau of Medical Services to Serve as the Licensing Agency</i> - Establishes the regulatory policy for the construction and operation of hospital or clinic in 	<ul style="list-style-type: none"> - For information - Regulate practice setting

Policy (Implementing Agency)	Main Provisions/Features	Implications for private MDs' participation
	the country	
R.A. No. 9184 (Government Procurement Reform Act of 2002) (DBM)	<ul style="list-style-type: none"> - <i>An Act Providing for the Modernization, Standardization and Regulation of the Procurement Activities of the Government and Other Purposes</i> - Sets the guidelines for government's procurement activities, including procurement planning, bid solicitation, evaluation and award, implementation and termination of the bid contract, use of alternative methods of procurement, protest mechanisms, dispute resolutions and the imposition of civil liabilities and administrative sanctions. - Applies to the procurement of infrastructure project, goods and consulting services, regardless of source of funds (whether local or foreign), by all branches and instrumentalities of the government, its departments, offices and agencies, including GOCCs and LGUs. <p>Supersedes/amends prior procurement policies (E.O. No. 40, s. 2001; E.O. No. 262, s. 2000)</p>	<ul style="list-style-type: none"> - For information - Regulate sale of goods and services to govt
Executive Order No. 49, series 1993 (DOH)	<ul style="list-style-type: none"> - Directing the Mandatory Use of the Philippine National Drug Formulary Volume 1 as the Basis for Procurement of Drug Products by the Government 	- For information
DOH Administrative Order No. 51, series 1988 (DOH)	<ul style="list-style-type: none"> - Lists down essential drugs of proven safety, efficacy and quality at affordable cost. Limits government procurement to listed drugs and the basis for reimbursement of claims for drugs by members of PhilHealth. Included as vital drugs are TB drugs (isoniazid, rifampicin, pyrazinamide, ethambutol and streptomycin) 	- For information
DOH Administrative Order No. 55, series 1988 (DOH)	<ul style="list-style-type: none"> - <i>Implementing Guidelines for Department of Health Compliance with R.A. No. 6675</i> - Sets the DOH's own implementing guidelines for the Generics Drug Act of 1988 	- For information
DOH Administrative Order No. 62, series 1989 (DOH)	<ul style="list-style-type: none"> - <i>Requirements for Labeling Materials of Pharmaceutical Products</i> - Sets the font type, size and color, and the positioning of generic name of a drug product as printed in the label 	- For information
DOH Administrative Order No. 63, series 1989 (DOH)	<ul style="list-style-type: none"> - <i>Rules and Regulations to Implement Prescribing Requirements under the Generics Drug Act of 1988</i> - Delineates the guidelines on the proper prescription of drugs pursuant to the Generics Drug Act of 1988 	<ul style="list-style-type: none"> - For information - Regulate drug prescription
DOH Administrative Order No. 65, series 1992	<ul style="list-style-type: none"> - <i>Rules and Regulations to Implement Dispensing Requirements under the Generics Drug Act of 1988</i> - Delineates the guidelines on proper dispensing of drugs pursuant to the Generics Drug Act of 1988 - <i>Guidelines on Advertisement and Promotions to Implement the Generics Act of 1988</i> - Specifies the rules and regulations pertaining to the advertisement and promotions of 	<ul style="list-style-type: none"> - For information - Regulate drug dispensing

Policy (Implementing Agency)	Main Provisions/Features	Implications for private MDs' participation
(DOH-BFAD) Bureau of Food and Drugs Circular No. 01, series 1997 (DOH-BFAD)	pharmaceutical products - <i>Enforcement of the Requirements for Bioavailability Studies for Registration of Products included in the List B' under the DOH Administrative Order No. 67, series 1989</i> - Requires the conduct of bioavailability of certain drugs, including two TB drugs, namely: pyrazinamide (tablet) and rifampicin (capsule/tablet/syrup)	- For information
DOH Administrative Order No. 56, series 1989 (DOH-BFAD)	- <i>Revised Regulations for the Licensing of Drug Establishments and Outlets</i> - Specifies the requirements for obtaining license to operate any organization or companies involves in the manufacture, importation, repacking, distribution and/or sale of drugs or medicines	- For information
DOH Administrative Order No. 85, series 2000 (DOH-OSR)	- <i>Registration Requirements for a Government Agency Importing a Pharmaceutical Product with a Registered Counterpart Brand in the Philippines</i> - Sets down the licensing rules and procedures for government agencies that want to import drugs that similar but cheaper than locally available branded products.	- For information
DOH Administrative Order No. 69, series 2001 (DOH-BFAD)	- <i>Guidelines and Procedures in the Utilization of Funds for Drug Importation and Distribution for the Pharma 50 Project</i> - Specifies the guidelines and procedures in the use of funds for imported drugs to lower the price of selected by 50 percent.	- For information
DOH Department Order No. 367-H, series 2001 (DOH-BFAD)	- <i>Creation of Pharma 50 Project Management Unit</i> - Creates a unit within the BFAD to administer and supervise the DOH's Pharma 50 Project (i.e., the project intended to lower the price of selected drugs by 50 percent through parallel drug importation).	- For information
DOH Administrative Order No. 70, series 2002 (DOH-BFAD)	- <i>Licensing of Botikang Barangay in various Local Government Units</i> - With the goal of ensuring wide access low priced, good quality medicine, this A.O. sets the guidelines for the licensing of barangay-level pharmacies run by local government units, non-government organizations or community organizations	- For information
DOH Administrative Order No. 70-A, series 2002 (DOH-OHR-BHFS)	- <i>Revised Rules and Regulations Governing the Registration, Licensure and Operation of Hospitals and other Health Facilities in the Philippines</i> - Mandated under Hospital Licensure Act (R.A. 4226) - Specifies the procedures for securing and renewing license to operate hospitals or health facilities both in the public and private sectors. - Specifies the licensing requirements such as service capability, personnel, equipment and instrument, and physical plant for first-level, second-level and third-level referral hospitals and other health facilities	- For information

ANNEX 3: LIST OF EXISTING POLICIES CONCERNING THE DEMAND FOR TB SERVICES

Policy (Implementing Agency)	Main Provisions/Features	Implications for private MDs participation
PhilHealth In-Patient Benefit Package (PHIC)	<ul style="list-style-type: none"> - Promulgated under the National Health Insurance Act of 1995 (R.A. 7875) - Aims to provide a basic health insurance coverage for all Filipinos, indigents or otherwise. - As of Dec. 2002, the basic insurance covers only in-patient care services 	<ul style="list-style-type: none"> - For information - May increase demand for TB DOTS services
PhilHealth TB Out-Patient Benefit Package (PHIC)	<ul style="list-style-type: none"> - This an expansion of the basic health insurance coverage provided by PhilHealth. It includes an out-patient benefit package to eligible members with TB. - To be implemented in May 2003 	<ul style="list-style-type: none"> - For information - May increase demand for TB DOTS services
Disability and Sickness-Income Benefits for Government Workers (GSIS)	<ul style="list-style-type: none"> - Promulgated under the GSIS Act of 1997 (RA 8291) - Provides for increased and expanded social security protection of all government workers. The social security benefits include: <ul style="list-style-type: none"> - Disability benefits (which are granted to a member due to the loss or reduction in earning capacity caused by a loss or impairment of the of the normal functions of the member's physical or mental faculties as a result of an injury or disease); and - Optional pre-need coverage (for hospitalization products). - The Act specifies the requirements and procedures for enrollment, payment of premiums, and eligibility for benefit claims 	<ul style="list-style-type: none"> - For information - May increase demand for TB DOTS services
Disability and Sickness-Income Benefits for Workers in the Private Sector (SSS)	<ul style="list-style-type: none"> - Promulgated under the SSS Act of 1997 (RA 8282) - Provides for increased and expanded social security protection of workers in the private sector, including: <ul style="list-style-type: none"> - Disability benefits (which are granted to a member due to the loss or reduction in earning capacity caused by a loss or impairment of the of the normal functions of the member's physical or mental faculties as a result of an injury or disease); and - Optional pre-need coverage (for hospitalization products). - The Act specifies the requirements and procedures for enrollment, payment of premiums, and eligibility for benefit claims 	<ul style="list-style-type: none"> - For information - May increase demand for TB DOTS services
Employees' Compensation Program (SSS-ECC)	<ul style="list-style-type: none"> - Promulgated under P.D. No. 626, and amended later; administered by SSS - Provides a list of ailments which are deemed work-connected, such as pulmonary tuberculosis. - Specifies the procedures and requirements for claiming employee's compensation benefits by members with work-connected disabilities - The employees' compensation benefits are in addition to whatever the members may claim under the GSIS or SSS Disability Benefits schemes. 	<ul style="list-style-type: none"> - For information - May increase demand for TB DOTS services

Annex 4: List Of Participants in Policy Consultation Meetings Held For This Study

	Name	Company
1.	Mr. Carlos D. Da Silva	Association of Health Maintenance Organization of the Philippines
2.	Dr. Cynthia De Lara	Bureau of Corrections, National Bilibid Hospital
3.	Dr. Jaime Lagahid	Department of Health
4.	Dr. Supecha T. Pepito	Department of Science and Technology
5.	Dr. Thelma Navarrez	DepEd
6.	Dr. Ma. Corazon Dumlao	DepEd, HNC
7.	Ms. Cynthia Ilano	Dept. of Social Welfare and Development
8.	Dr. Melchor Frias	DLSU-HSC
9.	Dr. Victoria Dalay	DLSU-HSC TB Research Unit
10.	Dr. Dulce Estrella-Gust	DOLE
11.	Dr. Ricardo Pening	DSWD, PPISB
12.	Dr. Policarpio Joves	FEU-NRMF
13.	Dr. Juvencio Ordoña	Friendly Care
14.	Dr. Alberto Romualdez	FriendlyCare Foundation, Inc.
15.	Dr. Teresita J. Icasiano	Government Service Insurance System
16.	Dr. Clarissa Reyes	Government Service Insurance System
17.	Dr. Eduardo Banzon	Health Finance Policy & Service Sector
18.	Mr. Felix Dalay	KDPP-Milestone Information Mgmt. Center
19.	Ms. Loreta Labado	National Commission for Indigenous People
20.	Ms. Eden GraceLumilan	National Economic and Development Authority
21.	Ms. Arlene Ruiz	National Economic and Development Authority
22.	Dr. Teresita Cucueco	Occupational Safety & Health Center (DOLE)
23.	Dr. Madeline Valera	Philippine Health Insurance Corporation
24.	Atty. Leo O. Olarte	Philippine Medical Association
25.	Mr. Jomar Fleras	ReachOut Foundation International
26.	Dr. Alma Fausto	Social Security System
27.	Dr. Pag-Asa Fausto	Social Security System
28.	Dr. Maridel Borja	UP College of Public Health -DEBS
29.	Dr. Marilyn Lorenzo	UP College of Public Health HPDS
30.	Mr. Hilton Lam	UP-NIH
31.	Dr. Cora Manaloto	USAID
32.	Dr. Jose Hesron Morfe	UST DOTS Center

Annex 5: List of Participants in Focus Group Discussions Held for this Study

	Name	Affiliation
1	Dr. Erwin P. Fabros	Fortune Care
2	Dr. Jonathan Montagot	Fortune Care
3	Dr. Rene Pangilinan	Social Security System
4	Dr. Eduardo Banzon	Phil Health Insurance Corp.
5	Dr. Vicente Jose Velez	Philippine Chest Physician
6	Dra. Ma. Theresa Jodloman-Dumawal	Phil. Academy of Family Physicians
7	Dr. Edward dela Fuente	Phil. Academy of Family Physicians
8	Dr. Vicente Jose Velez	Philippine Chest Physician
9	Dr. Adrian Pena	Philippine Chest Physician
10	Dr. A.H. Villalon	Philippine Chest Physician
11	Dr. Cecile Tady	Philippine Chest Physician
12	Dr. Jaime Montoya	Philippine Chest Physician